ATOL: Art Therapy OnLine

Overcoming Organisational Challenges Together:

Art Psychotherapy within Central and North West London (CNWL) NHS Mental Health Services

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Art Psychotherapy in CNWL NHS Foundation Trust

As the largest community facing NHS organisation Central and North West London Foundation Trust (CNWL) is perhaps unique in its aspirations to place art psychotherapy as one of the core psychological therapies for patients diagnosed with severe mental health disorders. CNWL is the largest NHS employer of arts therapists and currently employs 43 arts therapists across the trust of which 25 are art psychotherapists. We work with some of the most transient and deprived populations within London. Of the 1.2 million members of the population that we serve, approximately 17% will have a severe mental health issue at some point in their life. There is high cultural diversity and mental health services are accessed by people of all cultural backgrounds. Our motto is ‘Wellbeing for life’.

But times have changed significantly in the last 10 years. Drop-in day services that used to be part of the culture of mental health services now barely exist, the open spaces for supportive exploration are limited to inpatient settings and in the community there is a greater reliance on structured evidence-based treatments.

Arts psychotherapies have a long history of working in mental health settings in the UK. Art Psychotherapy was first introduced formally to health care in the 1940s to relieve the symptoms of trauma in general care (Edwards, 2004). Often the professionals that facilitated sessions were artists or teachers (Waller, 1991). These were not psychotherapists or researchers and therefore the background to the interventions remained basic and pragmatic built upon 'child-centred' approaches (Waller, 1991). Even today, beyond patient feedback and observed outcomes there is little definition of the interactions that would normally take place between patient and therapist (Karkou, 2006; Luzzatto, 1997). Whilst there has been great interest in the 'process' in terms of generating hypotheses about the benefits of making art within a 'therapeutic relationship', (Gilroy, 2006) what happens in the relationship is considerably less well researched. Art Psychotherapy has only recently begun to engage with a more scientific approach to process validation (Gilroy, 2006). This shift in the culture of art psychotherapy being about how the profession bridges patient experience and quantifiable outcomes is reflected in the organisational aims of the NHS. Since the early 2000s the NHS has attempted to bridge two philosophies. The first aim is to be 'evidence-based' where there is a constant search for evidence that is indicative of 'what works for whom?'(Roth and Fonagy, 1996). This first type of evidence is usually framed in terms of symptomatic changes, qualified by large randomised controlled trials (RCT). The second aim is to be recovery focused. This means learning from the patient about how the patient can adapt to symptomatic or environmental challenges as well as how society can better adapt to their disability so that the patient can have the same opportunities to be members of an inclusive society as anyone else. It is notable that the recovery philosophy, like the medical approach, has been influenced by physical disorders, which are usually far more visible to change than are mental health disorders. (Davidson et al 2006).

Figure 1

Adapting to Changes in the NHS: Defining our Practice

As a profession, we have had to address the changes in how we practice, but the NHS is struggling with reduced real funding (after inflation and increased costs) and whilst we are slowly moving towards this goal of evidence-based practice it is not without its compromises. I know that one size does not fit all (Alegria et al., 2010) and that the randomised controlled trial may not offer a good enough representation of good practice (Persons and Silberschatz, 1998). However, there is both a requirement that we can spell out what we are doing and how we do it and however crude the method, RCTs are still one of the few impartial tools for evaluating practice.

Whilst the clinical case study offers a magnitude of data that offers a real glimpse into the emotional world of the therapist – patient experience, the lesser explored terrain of meaningful *quantitative* data is an area that I want to start with. I want to begin by drawing on some work that we have been doing that has helped us to examine the interactions, terminology and shared principles of practice between arts psychotherapists – that is art, music and dance movement therapies. The humble beginnings of such an enterprise took place when we employed a supervisor that could supervise across modalities. We began this journey in 2008, when the first arts therapies group supervision in our trust was set up and led by Tim Wright. By background Tim is an art psychotherapist, however his openness to the ways in which effective communication can occur through the arts medium and his knowledge of how services function, meant that he was in an ideal position to think about how one modality translates into another. This coincided with greater collaboration between arts therapists at the arts therapies service that I set up for Brent Mental Health Services in London some years ago. As time progressed, we became increasingly interested in the types of interactions that we feel make a change in the immediate, intermediate and long term. Case presentations can reveal our thoughts and we promoted spaces where we could see the work through the lens of the therapist and their capacity to empathise and sensitively work through often moving and subtle interactions.

But we also wanted to begin to link up our understandings of the therapies. So, more recently we have begun to look at ‘what work works for whom’, with the close support of Professor Peter Fonagy (Head of Research Department of Clinical, Educational and Health, University College London). In the first instance we set up a ‘Change Process Group’, which meets every four weeks and holds the task of defining what we do in practice that makes a difference. The professional development groups around the Trust had been attending to written papers and this led to some very lively discussions about what it is that people believe that they do in practice. This initial exploration led to 21 guiding principles of practice and six categories of active intervention.

1. Adaptation to the patient's psychological position in order to establish an alliance and working relationship. This also requires flexibility in the application of the approach.
2. Identify good mentalizing in the process.
3. Identify opportunities in the work that may break from rigid patterns of relating.
4. Facilitate exploration through verbal and non-verbal means
5. Address or acknowledging non-mentalizing.
6. Establish new patterns of relating that can inform patterns of relating outside of the session (for example, family, professionals, friends, mental health workers)
7. Titrate relational aspects according to emotional closeness- distance. This may require curiosity, broadening out, and so on (see specific competencies)
8. Within the session there is an emphasis on immediate change in areas of interpersonal functioning – (for example, affect regulation, collaboration, trust, finding a listener and working with ruptures in the relationship to restore a position of mentalizing.)
9. The therapist can use the non-verbal mediums in the therapeutic stance to model, collaborate and attune. [This process is evident in normal interpersonal dialogue. A large part of how people talk is made up of nonverbal communication.]
10. It may be that using the arts medium is an important preparation and exploration for the acquisition of meaningful language.
11. The arts psychotherapist is in a position to respond with the arts medium using a feeling tone to help the patient link affect and words.
12. To be cautiously explorative and think about the level of your involvement and whether you need to meet them at a nonverbal level through the arts medium.
13. To not be too passive except in situations where the person cannot return to a state of mentalizing (for example, high states of affect) or

where there is such fragility that any intervention will be experienced as intrusive. [In community settings, it is questionable whether patients with such ego fragility would be accepted due to the long-term nature of change, however, each case must be assessed on a case-by-case basis.]

14. There is a range of non-verbal and verbal techniques that should be employed to alter underlying factors of communication – for example, enabling the patient to mobilize attuned states of mind and to establish a capacity to be imaginative. (see specific competencies)
15. Stimulating a capacity to be imaginative is central to the model, however it is important to limit the imagination to a grounded exploration of the interpersonal context and aim of the task to mentalize.
16. The arts psychotherapist should never work on their own with severe mental health disorders. The arts psychotherapist is required to perceive himself or herself as part of a wider context, including the team and/ or clinical supervisor. This also requires that sufficient knowledge about the patient's progress, risk factors and treatment is passed to other professionals involved in the patient's care.
17. It is important to know the biases and limitations that the practitioner brings with them. Arts psychotherapists all have their strengths in different areas and must know their limitations in terms of their capacity to treat specific patients according to the approach and arts mediums employed.
18. The model does not pay emphasis to insight or an internal self-cohesion but aims at allowing the person to co-exist within an interpersonal complexity of multiple perspectives.
19. The therapist should always develop treatment aims and offer a treatment plan in collaboration with the patient.
20. Whilst valuable hypotheses may be informed through the transference and counter-transference experience, these tools are used to

tentatively explore the patient's worldview rather than name experiences, feelings and thoughts for the patient.

21. Through using the medium, the therapist is attentive to the facilitation of embodied communication.

Mentalizing

It was notable that the arts psychotherapies interventions often appeared to aim at enabling the patient to reflect on their own mind in relation to others and vice versa: developing the capacity to 'hold mind in mind'. In many mental health disorders there is a basic problem with imagining what might be happening for the other person that seems to underpin many of the symptomatic concerns (Bora et al., 2009; Dolan and Fullam, 2004; Inoue et al., 2004; Sossin, 2007; Wolf et al., 2010).

So that we were sure that we really were speaking the same language and not 'over imagining' what was happening for our colleagues, we made videos of role plays of clinical scenarios that illustrate what we believe we had been describing in words. The overlaps between the nonverbal techniques introduced were of interest to the group, as was the sense that we could begin to use a shared language between the arts therapies for what we believed we were doing in therapy. I am going to play a number of videos, each gives a sense of the ways in which each therapist utilized a particular technique towards enabling a capability towards 'mentalizing'. This challenged some of the language that we had adopted. For example we tended to focus on a capacity to form symbols, but we were now thinking about this again in the interpersonal context.

> 'The term symbolization is over-burdened with meanings, particularly in psychoanalysis. It is certainly not possible to restrict it to the notion of the secondary representation of mental states. For the sake of brevity *I would like to label the capacity to conceive of conscious and unconscious mental states in oneself and others as the capacity to mentalize*.' (Fonagy, 1991, p. 641)[italics mine]

The role plays weren't rehearsed as we wanted to give them a live feel and to allow for error and what might happen normally. The therapists playing the patients also had to truly step into the position of another, perhaps something that is central to what we are helping our patients to do.

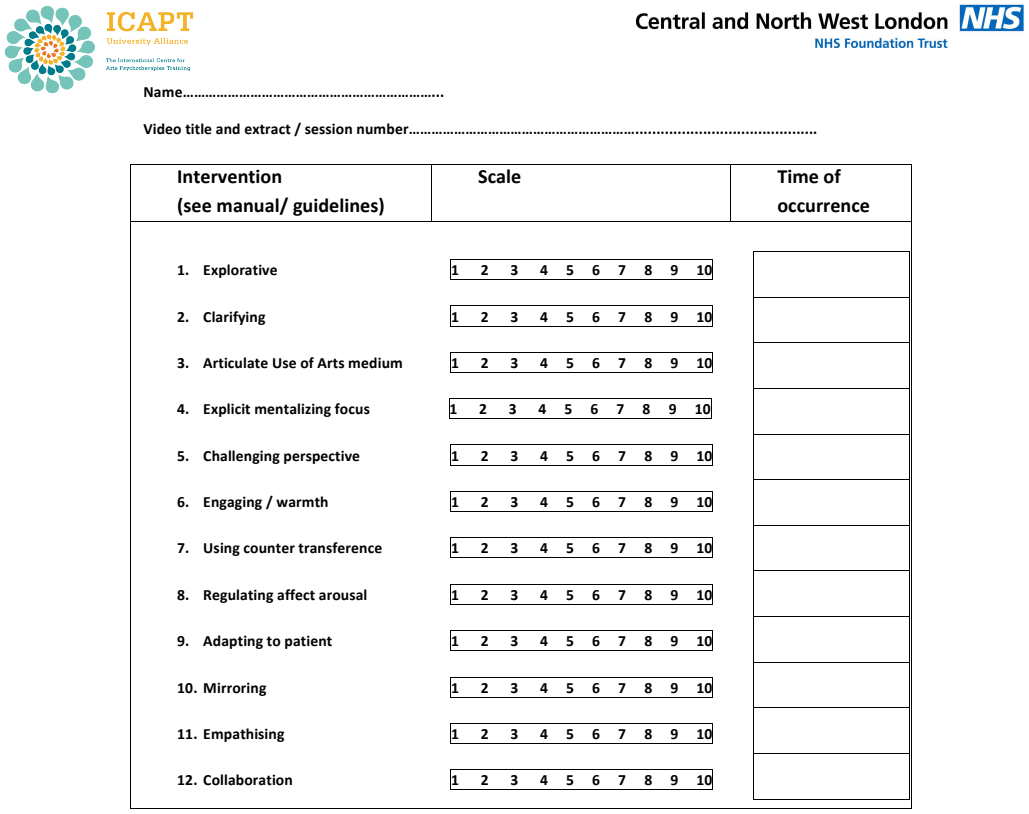
VIDEO EXTRACTS (4mins)

From the videos, you can begin to see that amongst the therapists there is a shared culture of empathy, understanding, clarification, the use of counter-transference to inform their response, monitoring the transference (not working in it) and perhaps most consistent is the sense of a genuine curiosity in the other.

What is also evident is that there is a different style for how each therapist behaves and uses the medium, also that there are moments of non-clarity, some 'bumbling about' and that these qualities are considered to be important to the therapeutic process: part of our humanness.

Testing Our Clinical Hypotheses

The testing of our theoretical hypotheses happened within the clinical interactions and is evidenced by the patient's change in mental state and functioning. What is it that the therapist is doing and how does the patient respond? Examining the therapist's actions seems to offer a clearer picture in terms of what enables better relations with others for the patient. When we examined the interactions and what had had an impact, we agreed on a number of areas as being central to the therapist's interventions. We saw that these can be observed in practice.



ICAPT University Alliance
The International Centre for Arts Psychotherapies Training

Central and North West London NHS
NHS Foundation Trust

Name.....

Video title and extract / session number.....

Intervention (see manual/ guidelines)	Scale	Time of occurrence
1. Explorative	1 2 3 4 5 6 7 8 9 10	
2. Clarifying	1 2 3 4 5 6 7 8 9 10	
3. Articulate Use of Arts medium	1 2 3 4 5 6 7 8 9 10	
4. Explicit mentalizing focus	1 2 3 4 5 6 7 8 9 10	
5. Challenging perspective	1 2 3 4 5 6 7 8 9 10	
6. Engaging / warmth	1 2 3 4 5 6 7 8 9 10	
7. Using counter transference	1 2 3 4 5 6 7 8 9 10	
8. Regulating affect arousal	1 2 3 4 5 6 7 8 9 10	
9. Adapting to patient	1 2 3 4 5 6 7 8 9 10	
10. Mirroring	1 2 3 4 5 6 7 8 9 10	
11. Empathising	1 2 3 4 5 6 7 8 9 10	
12. Collaboration	1 2 3 4 5 6 7 8 9 10	

Figure 2

But why are we investing so much time and effort in this kind of detail? Simply because we are in a position where we need to get things right. There is a lot at stake in this current climate and we have seen neighbouring trusts lose 30, 50, 70% of their therapists in different settings. And I can say that when we started this project we were in a position where the profession was being rigorously questioned. The results of the Matisse trial (Crawford and Patterson, 2007; Patterson et al., 2011) demonstrating no significant clinical change for art psychotherapy had been released, the world had changed since the profession was established in the 80s and we were concerned that we were being left behind. Care packages were being designed based on evidence-based care, and 'Payment by Results' was in the pipeline. The recovery agenda meant that there was a greater use of the voluntary sector that was replacing some of the services we had traditionally provided, and we found ourselves squeezed between the medically-informed, emerging evidence-base and the recovery agenda. This appeared to be the worst time for the NHS in terms of organizational change, pressure to perform

and the rigorous evaluation of practice that was being applied, and we were taking as much responsibility as we could for what should happen next.

The International Centre for Arts Psychotherapies Training (ICAPT)

CNWL senior managers, despite embracing innovation and creative approaches, were not won over easily. We needed to demonstrate that we were 'evidence-based'. We could see that there were practices that were using mentalizing as an outcome of treatment, including Mentalization-Based Therapy for families and for adolescents that had been developed within our trust, and that mentalization-based practice was coming on to the scene as a recommended treatment in NICE guidelines. Eia Asen, Clinical Director of the Marlborough Family Centre, made a significant contribution in helping us to think about mentalizing in arts-based practice. We felt that we had established a good foothold that couched what we already did within an evidence-based framework. Organisationally, there were a number of factors that fed into clarifying what we have now called 'mentalization-based arts psychotherapies'.

There was the longer term vision, steering through the difficult time – this depended on us listening to what academics and researchers had to say – in particular, Professor Helen Odell Miller, Professor Diane Waller, Professor Helen Payne, Professor Peter Fonagy and with special thanks to Lizzie Taylor Buck. We put ourselves into the open and began training others in the knowledge that we had gained, and shared, reflections on our own work. We made links with organisations abroad and set up placement schemes tailored for international students. We began to familiarize ourselves with the research culture and we embraced this under the canopy of ICAPT.

Figure 3

We launched ICAPT in November 2011 as a way of addressing the bigger picture and of creating an opportunity during the hardest time that I have had in my working history. ICAPT started on the day that the Matisse results were released and is gradually growing to become an established part of CNWL. We have trained over 200 qualified arts therapists in the mentalization-based arts psychotherapies where music, drama, art and dance-movement therapists come together to learn. We have had remarkable feedback.

Holding Our History in Mind Whilst Bridging the Gap

The important thing is that we do not lose touch with the invaluable roots of our profession. Whilst there has been huge headway in the verbal therapies in evidence-based practice that we have absorbed, it is important to note that verbal therapies have their limitations, especially with patients diagnosed with severe mental health disorders. Early pioneers such as Joy Schaverien, Katherine Killick and John Henzell showed the

way, working with some of the most complex patients, particularly with psychotic disorders. The first descriptions of how unconscious content was revealed through image making were lucidly described. For example, Schaverien writes,

> 'The picture may reveal much of the inner world landscape of the patient. The dream space may come to 'life' in the session through the picture. This may be like a dream, dreamed in the presence of the therapist' (Schaverien, 1999, p. 65).

It is a difficult task to find a language for the production of the image and the spontaneous emergence of its content. However, building upon the premise that is explicitly stated by Schaverien, that the image is a place where unintentional content arises expresses the uniqueness of art psychotherapy.

We know that the NHS is changing. The NHS was a place that was established to provide free care at the point of contact, in adult services it is at risk of becoming a place that provides free care if you are at the point of severe crisis or require short-term treatment. Many patients with psychological disorders are not receiving treatment beyond medication and monitoring. The NHS is at risk of losing touch with its guiding principle laid out by Nye Bevan,

> '…no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means' (Aneurin, 1952).

Amongst all of the psychological therapies we offer something that patients can engage with during times of crisis, helping people make sense of their experience, but more importantly enabling people to communicate with others more effectively. However, this will not win over NHS mental health commissioners in the long term. In the long term, our roles in the NHS will depend on how we define what we do: with clarity, a shared language and an ability to determine, explicitly, what exactly it is we do that makes the difference.

Biography

Dominik Havsteen-Franklin has been employed by CNWL in various roles since 1999, including as an art psychotherapist, team manager/clinical lead and interim head of profession. He is responsible for developing and implementing clinical arts therapies training for internal arts psychotherapists and providing training packages external to the trust. He is also leading on the research arm of ICAPT focussing on severe mental health disorders and psychological therapies. He is completing his PhD in art psychotherapy and metaphor at Essex University.

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